Dependent Services (continued)

- **Home Health Aides**
- Medical social services
- Medical supplies (related to the illness/injury)
  - Examples: catheters, ostomy supplies
  - Not DME/Prosthetics & Orthotics → Covered separately under Part B

42 U.S.C. § 1395x(m)(7)(b)

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Home Health Aides—Law

How much can be covered – under the law?

- Combined with skilled nursing, can be provided up to 28 hours per week and any number of days per week as long as they are provided less than 8 hours each day
  - Subject to review on case by case basis, they may be available up to 35 hours per week
- Separately if the skilled service is therapy

42 U.S.C. § 1395x(m)(7)(b)
42 CFR §409.45(b)

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Home Health Aides—In Practice

How much can be covered – in practice?

- Too often told only 1 – 3 hours/week
  - Only for a bath
- Or, not available staff to provide
  - What if private pay?

- **Note:** Can mix payment sources

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Home Health Aides (continued)

- HH aides must provide **hands-on personal care**
  - Homemaker services alone are *not* covered
    - Only if incident to hands-on personal care
- "Custodial" Care
  - Medicare Act specifically establishes home health aide (custodial care) as a covered service under the Medicare home health benefit

42 U.S.C. § 1395x(m);
42 C.F.R. § 409.45(b)

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Home Health Aides (continued)
42 CFR §409.45(b)(1) – (4)

What is *Hands-on Personal Care*?

- Specifically defined to include:
  - Bathing, dressing, grooming, caring for hair, nails, oral hygiene to facilitate treatment or prevent deterioration
  - Changing bed linen of incontinent patient
  - Feeding assistance with elimination, routine catheter and colostomy care, skin, foot, ear care
  - Assistance with ambulation, changing position in bed, help with transfers
  - Assistance with Rx that doesn't require nurse

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Is Coverage Available If Caregivers Are At Home?

- A patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services …
- Ordinarily it can be presumed that there is no able and willing person at home to provide services rendered by the home health aide or other HH personnel

Medicare Benefit Policy Manual, Ch. 7, Sec. 20.2

Jimmo vs. Sebelius

Impact on Medicare Home Health Care

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Jimmo V. Sebelius, No. 5:11-cv-17 (D. Vt. 2011), Settled 2013, Corrective Action Plan 2017

- Federal class action brought to end Medicare denials based on an "Improvement Standard" for skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) care.
- **Filed Jan. 18, 2011**; Settled October 2012 (Court approved 1/2013); Back to Court for further implementation: 3/1/2016; CMS Corrective Action Plan **completed 2017.**
- Plaintiffs: 5 individuals and 6 organizations
    1. National MS Society
    2. Alzheimer's Association
    3. National Committee to Preserve Social Security & Medicare
    4. Paralyzed Veterans of America
    5. Parkinson's Action Network
    6. United Cerebral Palsy

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What *Jimmo* Means (1 of 2)

- Care that meets Medicare home health coverage criteria:
  - Doctor's order, homebound, skilled care; and
  - Is needed to maintain an individual's condition or slow decline…
- Is just as coverable by Medicare as care to improve an individual's condition.

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What *Jimmo* Means (2 of 2)

Coverage does not turn on the presence or absence of potential for improvement, but rather on the need for skilled care

- Includes Nursing and Therapy

Services can be skilled and covered when:

- Skilled professional is needed to ensure services are safe and effective
- To maintain, prevent, or slow decline

Medicare Benefit Policy Manual, Ch.7, Sec. 20.1.2

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Nursing to Maintain Function or Slow Deterioration

- Maintenance nursing services are Medicare-coverable when skilled nursing is necessary to maintain current condition or prevent or slow deterioration so long as the skills of a nurse are required to ensure the services are safe and effective

Medicare Benefit Policy Manual, Ch. 7, Sec. 40.1.1

- Decision regarding coverage should turn on whether skilled nursing is needed, not whether individual is expected to improve.

Medicare Benefit Policy Manual, Ch. 7, Sec. 20.1.2

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Therapy to Maintain Function or Slow Deterioration

- "Maintenance Therapy"
  - Where services that are required to maintain current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to perform the procedures safely and effectively, the services would be covered physical therapy services."

Medicare Benefit Policy Manual, Chapter 7, Sec. 40.2.2.E

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Jimmo and Prior Law Support Maintenance Coverage and Require an Individualized Assessment

- Restoration potential is not the deciding factor
  - 42 CFR §409.32(c)
- Medicare should not use "rules of thumb"
- Must make "Individualized Assessment"

"Determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time."

42 C.F.R. §409.44(b)(3)(iii)
See also: 42 C.F.R. §409.44(a)

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Jimmo Summary

Questions to Ask:

- Is a skilled professional needed to ensure nursing or therapy is safe and effective?
  - **If yes → Medicare coverable**
- Is a qualified nurse or therapist needed to provide or supervise the care?
  - **If yes → Medicare coverable**

Regardless of whether the skilled care is needed to improve, maintain, slow deterioration of the condition, or if condition is *chronic*, *stable*, or has *plateaued*.

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Case Example #1

- A patient was discharged from the hospital with an open draining wound that requires irrigation, packing, and dressing twice each day. The home health agency (HHA) has taught the family to perform the dressing changes. The HHA continues to see the patient for the wound care that is needed during the time that the family is not available and willing to provide the dressing changes. The wound care continues to be skilled nursing care, notwithstanding that the family provides it part of the time, and may be covered as long as the patient requires it.

Medicare Benefit Policy Manual, Chapter 7, Section 40.1.1, Example 5 (page 42)

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Case Example #1 - Analysis

- Patient leaves the hospital with a Physician's Order and Plan of Care for home health services, specifically wound care. She has had a Face-to-Face Encounter and she meets Homebound criteria.
- Order and Plan of Care include wound irrigation, packing and dressing which are skilled services, due to the complexity of caring for wounds, and the need for skilled observation and assessment for changes in condition (such as infection).
- Home health agency, chosen by the patient, performs a needs assessment to confirm specific goals.
- Family, if any and if willing and able, may be trained to safely and effectively perform some of the skilled tasks, some of the time.
- If wound care is daily, home health care can continue for 21 days (or longer if the physician indicates a predictable and finite end point).
- If wound care is not daily, services may be covered for as long as the patient needs.

Case Example #2

A Parkinson's patient may require the services of a physical therapist to determine what type of exercises are required to maintain the patient's present level of function or to prevent or slow further deterioration. The initial evaluation of the patient's needs, the designing of the maintenance program appropriate to the patient's capacity and tolerance to the treatment objectives of the physician, the instruction of the patient, family, or caregivers to carry out the program safely and effectively (unless the condition of the patient is such that a skilled therapist is needed to ensure the care is delivered safely and effectively), and such re-evaluations as may be required by the patient's condition would constitute covered skilled therapy. Each component of this process must be documented in the health record.

Medicare Benefit Policy Manual, Chapter 7, Section 40.2.2, Example 5 (page 69)

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Case Example #2 - Analysis

- Patient has a Physician's Order for a Physical Therapy (PT) evaluation. He has been at home (not in a hospital or other institution) and had a Face-to-Face Encounter with his treating provider and he meets Homebound criteria.
- Following the PT evaluation, the treating provider completes a Plan of Care with goals to prevent or slow decline in function.
- Home health agency, chosen by the patient, performs a needs assessment to confirm specific goals and design a PT program.
- Family and caregivers, if any and if willing and able, may be trained to safely and effectively perform some of the tasks, some of the time.
- Some services may usually not require a skilled PT (e.g. range of motion exercises) but patient's condition determines if skilled PT is needed for safe/effective services.
- Continual PT re-evaluations needed to assess effectiveness, safety, change in condition, re-designed and ongoing PT programs (hence, discharge not appropriate).

Case Example #3

A physician has ordered home health aide visits to assist the patient in personal care because the patient is recovering from a stroke and continues to have significant right side weakness that causes the patient to be unable to bathe, dress or perform hair and oral care. The plan of care established by the patient's home health aide nurse sets forth the specific tasks with which the patient needs assistance. Home health aide visits at an appropriate frequency would be reasonable and necessary to assist in these tasks.

Medicare Benefit Policy Manual, Chapter 7, Section 50.2, Example 1 (page 76)

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Case Example #3 - Analysis

- Patient has a Physician's Order for Skilled Service(s) and Home Health Aides. Following her stroke, she had a Face-to-Face Encounter with her treating provider and she meets Homebound criteria.
- The treating provider completes a Plan of Care with goals for Skilled Service(s) for home health services related to recovery from her stroke.
- Services of an Aide are ordered to complete unskilled tasks patient cannot do (in this case: bathe, dress, oral care and hair care).
- Home health agency, chosen by the patient, performs a needs assessment to confirm specific goals and personal care needs.
- Family and caregivers, if any and if willing and able, may be trained to safely and effectively perform some of the tasks, some of the time.
- Personal care needs include many more services. Find them at: 42 CFR § 409.45

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Medicare Home Health Care Access

Current Obstacles to Getting Care

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Obstacles To Care: Misinterpretation Of Coverage Laws

- By Home Health Agencies
- By Medicare Contractors
- Lack of understanding about *Jimmo*
- Fear of Medicare Audits

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Obstacles To Care: Medicare Payment Models

- Payment case-mix weights are not strong for people living with a chronic condition.
- Medicare certified home health agencies are not required to provide services to all Medicare patients.
- However, Medicare certified home health agencies are not allowed to discriminate by payer source.
- Medicare payments are higher for patients starting home health services within 14 days of being hospitalized.
- Medicare payments to home health agencies for patients served for more than 30 days are decreased.

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Obstacles To Care: Quality Rules

- Impact of the current Home Health Quality Reporting Program (HHQRP) and the "star rating" system measures include these "improvement" measures:
  - How often patients got better at walking around
  - How often patients got better at getting in and out of bed
  - How often patients got better at bathing
  - How often patients had less pain when moving around
  - How often patients' breathing improved
  - How often patients' wounds improved or healed after an operation

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Obstacles To Care: Arbitrary Discharge

- The patient still qualifies for care, but the home health agency says:
  - Medicare won't pay for your care any more
  - Medicare doesn't cover long term services
  - Medicare doesn't cover maintenance therapy
  - We don't have the staff to meet your needs
  - You only need custodial care and Medicare doesn't pay for that
  - You are not homebound

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Medicare Home Health Care

Advocacy Tools
& Practical Tips

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Review and Refer to Medicare Home Health Law & Regulations

- Medicare Act: 42 USC §1395x(m)
- Federal Regulations: 42 CFR §409.40
- See: New CMS MLN re Role of Coverage Law and Therapy under Home Health Patient Driven Groupings Model (PDGM) (2/10/2020)

Visit: www.MedicareAdvocacy.org

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Refer to the Medicare Conditions Of Participation (COP) (Revised 1/13/2018)

- First major update to COP in over 25 years
- Generally expands beneficiary protections
- Affords greater protections for patients from arbitrary transfer or discharge from home health care
- Establishes an updated Patient Bill of Rights that must be clear and accessible to patients and home health staff
- Enhances patient assessment requirements to include psychosocial, functional, and cognitive components
- Requires more significant consideration of patient preferences

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Refer to the Medicare Conditions Of Participation

- Requires more patient involvement in care planning:
  - Includes patients, representatives, and aides on an interdisciplinary care team
  - Establishes more communication between patients, care representatives, and the home health agency
- Mandates home health agencies identify caregivers and their willingness/ability to assist with care (not assume it's available).
- Requires coordination/integration with all patient's physicians.

42 C.F.R. § 484.2 et. al.

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Refer to the Medicare Conditions Of Participation (Continued)

- Discharge and Transfer of Patients
  - Discharge is appropriate only when a physician and home health agency both agree that the patient has achieved measureable outcomes and goals established in the individual plan of care. (Note: Goals may include slowing deterioration of a condition or maintaining a condition.)
  - Home health agencies are responsible to make arrangements for safe and appropriate transfer of a patient to another agency.

42 C.F.R. § 484.50(d)(1); 42 C.F.R. § 484.50(d)(3)

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Refer to the Medicare Benefit Policy Manual

- Medicare-certified Home Health Agencies rely on the Medicare Benefit and Policy Manual
- Medicare Benefit Policy Manual, Chapter 7
  - All significantly revised by *Jimmo*
  - Section 20 (Medicare decisions should be based on whether skilled care is needed, not on whether individual will improve)
  - Section 30 (Homebound)
  - Section 40 (Coverage, including for nursing and therapy to maintain or slow decline)

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Visit Medicare Websites

- **CMS.gov:** Search for "*Jimmo*" for information about the *Jimmo* case and legal criteria, reiterating improvement is not required

- **Medicare.gov:** Review the **Home Health Compare** tool, it will provide contact information for all Medicare certified home health agencies that serve your zip code.
  - Contact agencies, including those that do NOT have 5 Star Ratings

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Refer to the CMS *Medicare & Home Health Care Booklet*

- Official CMS Booklet—October 2017 version contains significant updates and clarifications
  - Medicare and Home Health Booklet
- Topics include:
  - Medicare Coverage of Home Health Care
  - Choosing a Home Health Agency
  - Getting Home Health Care – including plan of care and a checklist for care needs
- Not perfect, but a strong advocacy tool

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Confirm There's Clear Documentation In Beneficiary's Medical Record

- Be certain orders and goals clearly indicate maintenance language if that is the intended outcome
- If improvement is initially expected and that goal is reached or changed:
  - **Get new order, with new goals if goal changes from improvement to maintain, deter, or slow decline**
  - Denials occur when this is not done
- Confirm the services are documented as delivered – "If it's not documented, it didn't happen."

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Confirm There's Clear Documentation In Beneficiary's Medical Record (Cont)

- Need for and receipt of skilled care must be evident
  - Document skilled care was needed and provided
- There are no magic words required in documentation:
  - But vague phrases like "patient tolerated treatment well," "continue with Plan of Care," "patient remains stable" are not sufficient to establish coverage.
  - Include language stating skilled nursing and/or therapy are required to maintain or slow and deter and why.
- If improvement does occur, document it!

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Case Consultations

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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